

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN1915	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  04/10/2013	
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING AND REHABILITATION-MA		STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  An annual Licensure Survey and complaint investigation #s 30484, 30757, 30781, 31052, 31398, were completed on April 11, 2013. No deficiencies were cited under Chapter 1200-8-06, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

6899

W6S011

If continuation sheet 1 of 1